Dear Applicant:

Enclosed you will find the forms necessary for you to apply for licensure as a Professional Art Therapist. It is strongly suggested that you read the regulations prior to filling out the application, and then examine the directions entitled **"STEPS TO LICENSURE"** to see which forms are appropriate for you. Please note the following:

(a) Applications not completed in their entirety will be returned, minus the applicable fee, which is non-refundable.
(b) The photograph must be a "passport-style" photo.
(c) The practice history must be current and complete (see enclosed form).
(d) The names on the application and the requirements for licensure must match the name on the driver's license or U.S. Social Security Card. We will not accept nicknames, abbreviations, or alterations.
(e) The home address on the application is the address where this office will mail all correspondence. Written notice signed by the applicant is required for an address change.
(f) All checks/money orders for fees are to be made payable to the Mississippi State Department of Health (MSDH).
(g) The review process regarding an application for licensure starts only after all applicable requirements are on file. The review process is usually completed within two weeks.
(h) Our overnight mail address (see "**OVERNIGHT MAIL**") is as follows:

Mississippi State Department of Health
Professional Licensure - Art Therapy
570 East Woodrow Wilson Blvd.
Jackson, MS 39216

"*No person shall use the title 'licensed professional art therapist' or hold himself out as having this status, unless he is licensed as such by the Board."*

Thank you for considering Mississippi for your practice. Please contact the licensure office if you need any assistance.

Sincerely,

Stephanie Boyette
HPS, Sr.

STEPS TO LICENSURE
as a
PROFESSIONAL ART THERAPIST

Enclosed is a packet for licensure as a Professional Art Therapist. Two types of licensure are currently issued in Mississippi: Regular and Provisional. The requirements for each are as follows:

1. **Regular**

    a. Completed, notarized application.
    b. Application fee - $100.00 (non-refundable).
    c. Copy of current ATR-BC certificate from the ATCB
    d. Verification of all licenses, registrations, and/or certifications as an art therapist, current or not current, reported directly from the issuing authority (with seal).

2. **Provisional**

    a. Completed, notarized application.
    b. Application fee - $100.00 (non-refundable).
    c. Proof of education reported directly from the institution.
        1) Verification of Education for Licensure Form; and,
        2) A certified transcript of graduation of a master's or doctoral degree in art therapy from an institution accredited by the American Art Therapy Association; or,
        3) A certified transcript of graduation of a master's or doctoral degree in a related field with a minimum of twenty-one (21) semester hours of sequential course work in the history, theory, and practice of art therapy or an equivalent major course of study as approved by the Department. NOTE: Degrees from non-accredited institutions will be reviewed on a case-by-case basis.
    d. A letter of supervision from the Licensed Professional Art Therapist under whose direct supervision the applicant will practice.
    e. Verification of all licenses, registrations, and/or certifications as an art therapist, current or not current, reported directly from the issuing authority (with seal).

All requirements must be on file and satisfactory to this office before a certificate may be issued.

PRACTICE HISTORY

Instructions: Please list the facility, home health agency, etc., its location (city & state), and the dates that you practiced at that facility in chronological order beginning with your last practice site. A resume' may be attached if the information needed to complete this history is on the resume'. This sheet may be copied if additional space is needed.

FACILITY	LOCATION	DATES
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Professional Art Therapist (PAT)

Application for Licensure

(Please type or print in ink)

Office Use

Check No._____

Amount $_____

Date ____/____/____

Licensure Type

Regular ☐ Provisional ☐

Personal

Name: _____
(Last) (First) (Middle)

Home Address: _____
(Street)

_____ Telephone Number (_____)_____
(City) (State) (Zip Code) (County)

U.S. Social Security No. ☐☐☐ - ☐☐ - ☐☐☐☐ Date of Birth: ☐☐ - ☐☐ - ☐☐

Race:_____ Sex: Male ☐ Female ☐ U.S. Citizen: No ☐ Yes ☐ Legal Alien: No ☐ Yes ☐ Visa Type & No.:_____

Professional

Employer: _____

Business Address:_____

_____ Telephone Number (_____)_____
(City) (State) (Zip Code) (County)

Practice Type

Insert # _____

1. Patient Care
2. Administration
3. Teaching
4. Research
5. Other Activity
6. Not Active as PAT

Practice Setting

Insert Primary # _____ Secondary #_____

1. >100 Bed Hospital
2. <100 Bed Hospital
3. Nursing Home
4. Detention Center
5. A & D Treatment Facility
6. School
7. Private Practice
8. Outpatient Facility
9. Other
10. Not Applicable

Education

Provisional Applicants: A Verification of Education form and a certified transcript must be submitted directly from the institution.

School _____
(Name) (City) (State) (Country)

Type of Degree _____ Date_____

Credential

Have you ever been licensed, certified or registered in any state, territory or country? No ❑ Yes ❑ If yes, list all jurisdictions (current/not current) including Mississippi. ***All regulatory documents must be verified by the jurisdiction - with board seal. (See License Verification Form.)***

1. _____ 4. _____ 7. _____ 10._____
2. _____ 5. _____ 8. _____ 11._____
3. _____ 6. _____ 9. _____ 12._____

Licensure *(continued)*

Have you ever had a license, registration, or certificate encumbered in any way, i.e., revoked, suspended, rejected, placed on probation, etc? *All action must be reported by the jurisdiction with the verification form.* No ☐ Yes ☐

Are there any criminal or civil suits pending against you? No ☐ Yes ☐

Have you ever been convicted of any violations of law (except minor traffic violations)? No ☐ Yes ☐

Have you ever been convicted of a felony related to the practice of Art Therapy? No ☐ Yes ☐

Certification **(See "Steps to Licensure")**

Are you currently certified by ATCB, Inc.? No ☐ Yes ☐

- If yes, attach a copy of your ATCB, Inc. Certificate.
- If no, list the date of the first exam you will be eligible for. _____ / _____ *(Month)* *(Year)*

Occupational Status

Attach completed Practice History form.

Fees

Make check or money order payable to:
Mississippi State Department of Health

Fees enclosed: $100.00 Application and Licensure (non-refundable)

$100.00 **Total**

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief. I have also read and understand the Regulations Governing Licensure of Professional Art Therapists and affirm that all conditions for licensure have been met and will be maintained.

_____
(Applicant's Signature)

Complete form, enclose fee and mail to:
Mississippi State Department of Health
Professional Licensure: Art Therapy
Post Office Box 1700
Jackson, Mississippi 39215-1700

Attach Copy of Driver's License or U.S. Social Security Card

Attach Photo

Subscribed and sworn to before me this _____ day

of _____, 19 _____.

My commission expires _____.

_____
(Notary Public)

Professional Art Therapist

Verification of Credential in Another State

To be Completed by Applicant *(Please print or type)* Social Security No.:_____-_____-_____

Name:_____

Credentialing Authority:_____ Number:_____ Date Issued: _____
(State, Territory, or Country)

_____
(Applicant Signature)

To be Completed by Secretary of Credentialing Board

Name: _____

Type of Credential: _____

Number: _____

Date Issued: _____

Expiration Date: _____

Issued By: State Exam: _____

Reciprocity with: _____

AACB, Inc. Credential: _____

Has credential ever been disciplined? ☐ No ☐ Yes *(if yes, please attach findings and disposition.)*

Remarks: _____

_____

_____

Board must return directly to:
Mississippi State Department of Health
Professional Licensure: Art Therapy
Post Office Box 1700
Jackson, Mississippi 39215-1700

_____
(Authorized Signature)

This document must show Seal of credentialing agency.

Seal

Professional Art Therapist (PAT)

Verification Of Education For Licensure

Instruction To Applicant: Upon completion of the demographic information and waiver below, this form should be signed, notarized, and forwarded to the college or university where you obtained your degree.

Name (Last, First, Middle Initial)	*Maiden Name or Given Surname*
Address (Street, City, State and Zip Code)	*Phone No.* *Home* ( ) *Work* ( )
Social Security Number	*Date of Graduation*

Waiver For The Release Of Information:

I am applying for licensure as a PAT in the State of Mississippi. I hereby authorize the verification of my degree conferred and further authorize the release of any transcript or other information, favorable or otherwise, to the Mississippi State Department of Health, Professional Licensure – Art Therapy, should this information be requested at any time.

_____ _____

Date *Signed*

Subscribed and sworn to before me this day of_____19____

My commission expires_____19_____.

_____

Notary Public

Seal

Instructions To Educational Institution:

Upon completion of this form please attach a certified transcript and send directly to:

Mississippi State Department of Health
Professional Licensure - Art Therapy
Post Office Box 1700
Jackson, Mississippi 39215-1700

Name of Institution	*Location of Institution (City&State)*
Dates of Attendance (Month/Year) From: To:	Has applicant successfully completed all academic requirements and field work requirements? ☐ No ☐ Yes, date _____
Date Degree Conferred	*Degree Conferred*
Program Name & Curriculum Description	*Practicum* Direct Client *(Individual, Group, Family)* Art Therapy Contact Hours: _____ Total Number of Hours: _____

Art Therapy Program Accreditation *(on date degree conferred)*

Program Accredited by AATA ☐ No ☐ Yes

Seal of the College or University

_____
Signature

_____
Title

_____
Telephone Number *Date*